

**Department for Behavioral Health, Developmental and Intellectual Disabilities  
Curriculum Application Form  
Community Support Associate Initial 10 Hour Training Requirements**

**Today's Date:**

**Provider Information**

Name of Provider:

Mailing Address Line 1:

Mailing Address Line 2:

City, State, Zip Code:

**Contact Person**

Name of Person Completing this Form:

Phone Number:

Email Address:

**Author of Curriculum\***

Author Name:

Phone Number:

Email Address:

**\*Are you submitting, with permission, a curriculum with no revisions owned by another entity that has previously submitted to DBHDID? Yes \_\_\_\_ No \_\_\_\_**

**With this form, please include a USB flash drive with the curriculum saved as a pdf file. On the flash drive, clearly label the flash drive with the provider's name and author. Thank you.**

**Submit this information to:**

**Laura Cunningham**

**Department for Behavioral Health, Developmental and Intellectual Disabilities**

**Division of Program Integrity**

**Program Support Branch**

**275 East Main Street, 4E-C**

**Frankfort, KY 40621**